FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044271

Facility Name: Grasmere Place

Address: 4621 N Sheridan Rd (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 334-6601 **Fax #** (773) 334-3619

IDPA ID Number: 364269374001

Date of Initial License for Current Owners: 02/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	216	Intermediate (ICF)	216	78,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	78,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	74,358	1		74,359	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	74,358	1		74,359	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.32%

D. How many bed-hold days during this year were paid by Public Aid?
1,998 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	168,557	31,838	18,055	218,450		218,450	(5,607)	212,843			1
2	Food Purchase		251,150		251,150	(28,616)	222,534	(115)	222,419			2
3	Housekeeping	196,650	40,590		237,240		237,240	(3,476)	233,764			3
4	Laundry		3,946	24,378	28,324		28,324	(23)	28,301			4
5	Heat and Other Utilities			135,449	135,449		135,449	1,948	137,397			5
6	Maintenance	116,320		95,387	211,707		211,707	6,509	218,216			6
7	Other (specify):*							3,813	3,813			7
8	**TOTAL General Services**	481,527	327,524	273,269	1,082,320	(28,616)	1,053,704	3,049	1,056,753			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	920,966	32,307	11,376	964,649		964,649	11,115	975,764			10
10a	Therapy							659	659			10a
11	Activities	104,341	11,347	14,160	129,848		129,848	35	129,883			11
12	Social Services	623,111	14,209	1,782	639,102		639,102	192	639,294			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							2,056	2,056			15
16	**TOTAL Health Care and Programs**	1,648,418	57,863	34,518	1,740,799		1,740,799	14,057	1,754,856			16
	C. General Administration											
17	Administrative	6,643		296,454	303,097		303,097	14,200	317,297			17
18	Directors Fees											18
19	Professional Services			350,467	350,467	(3,500)	346,967	(280,888)	66,079			19
20	Dues, Fees, Subscriptions & Promotions			54,146	54,146		54,146	(24,689)	29,457			20
21	Clerical & General Office Expenses	129,785	18,203	107,806	255,794		255,794	74,287	330,081			21
22	Employee Benefits & Payroll Taxes			382,288	382,288	28,616	410,904	(22,884)	388,020			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,408	1,408		1,408	937	2,345			24
25	Other Admin. Staff Transportation			6,549	6,549		6,549	(4,860)	1,689			25
26	Insurance-Prop.Liab.Malpractice			119,850	119,850		119,850	11,009	130,859			26
27	Other (specify):*							34,699	34,699			27
28	**TOTAL General Administration**	136,428	18,203	1,318,968	1,473,599	25,116	1,498,715	(198,188)	1,300,527			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,266,373	403,590	1,626,755	4,296,718	(3,500)	4,293,218	(181,083)	4,112,135			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Grasmere Place #0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			20,039	20,039		20,039	365,257	385,296			30
31	Amortization of Pre-Op. & Org.							160,366	160,366			31
32	Interest			3,482	3,482		3,482	557,451	560,933			32
33	Real Estate Taxes					3,500	3,500	128,554	132,054			33
34	Rent-Facility & Grounds			940,524	940,524		940,524	(935,735)	4,789			34
35	Rent-Equipment & Vehicles			8,552	8,552		8,552	2,266	10,818			35
36	Other (specify):*							54,950	54,950			36
37	**TOTAL Ownership**			972,597	972,597	3,500	976,097	333,109	1,309,206			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,260	118,260		118,260		118,260			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			118,260	118,260		118,260		118,260			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,266,373	403,590	2,717,612	5,387,575		5,387,575	152,026	5,539,601			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,518)	30		9
10	Interest and Other Investment Income	(135,858)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(0)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,725)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,197)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(33,792)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (239,090)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	391,116		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 391,116		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 152,026		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Grasmere Place

ID# 0044271

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COPE	$ (2,747)	20	1
2	Jury Duty Income	(52)	10	2
3	Collection Expense	(67)	21	3
4	Bank Charges	(4,409)	21	4
5	Misc. Income	(22,018)	21	5
6				6
7	Audit Fee (Bldg Co)	(4,375)	19	7
8	Bank Charges (Bldg Co)	(24)	21	8
9	Trust Fees (Bldg Co)	(100)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
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98				98
99				99
100				100
101	Total	(33,792)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grasmere Place # 0044271 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			64		(3,632)			(2,039)				(5,607)	1
2	Food Purchase	(0)		(115)									(115)	2
3	Housekeeping					1,221			(4,697)				(3,476)	3
4	Laundry								(23)				(23)	4
5	Heat and Other Utilities			1,948									1,948	5
6	Maintenance			2,033	6	4,470							6,509	6
7	Other (specify):*				2,580	1,233							3,813	7
8	**TOTAL General Services**	(0)		3,930	2,586	3,292			(6,759)				3,049	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(52)		258		14,115			(3,206)				11,115	10
10a	Therapy					659							659	10a
11	Activities			35									35	11
12	Social Services					196			(4)				192	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				234	1,822							2,056	15
16	**TOTAL Health Care and Programs**	(52)		293	234	16,792			(3,210)				14,057	16
	C. General Administration													
17	Administrative					14,200							14,200	17
18	Directors Fees													18
19	Professional Services	(4,375)	4,375	(280,888)									(280,888)	19
20	Fees, Subscriptions & Promotions	(6,472)		(18,217)									(24,689)	20
21	Clerical & General Office Expenses	(88,815)	974	21,663		140,885			(420)				74,287	21
22	Employee Benefits & Payroll Taxes				(22,310)			(574)					(22,884)	22
23	Inservice Training & Education													23
24	Travel and Seminar			937									937	24
25	Other Admin. Staff Transportation			(4,860)									(4,860)	25
26	Insurance-Prop.Liab.Malpractice		9,398	1,611									11,009	26
27	Other (specify):*				15,537	19,162							34,699	27
28	**TOTAL General Administration**	(99,662)	14,747	(279,754)	(6,773)	174,247		(574)	(420)				(198,188)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(99,714)	14,747	(275,531)	(3,953)	194,331		(574)	(10,389)				(181,083)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grasmere Place # 0044271 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(3,518)	358,402	10,373									365,257	30
31	Amortization of Pre-Op. & Org.		160,366										160,366	31
32	Interest	(135,858)	672,895	20,414									557,451	32
33	Real Estate Taxes		125,660	2,894									128,554	33
34	Rent-Facility & Grounds		(940,524)	4,789									(935,735)	34
35	Rent-Equipment & Vehicles			2,266									2,266	35
36	Other (specify):*		54,950										54,950	36
37	**TOTAL Ownership**	(139,376)	431,749	40,736									333,109	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(239,090)	446,496	(234,795)	(3,953)	194,331		(574)	(10,389)				152,026	45

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 940,524	Grasmere Real Estate, LLC	100.00%	$	$ (940,524)	1
2	V	32	Interest Income	3,089	Grasmere Real Estate, LLC	100.00%		(3,089)	2
3	V	19	Audit Fee		Grasmere Real Estate, LLC	100.00%	4,375	4,375	3
4	V	21	Bank Charges		Grasmere Real Estate, LLC	100.00%	24	24	4
5	V	21	Trust Fees		Grasmere Real Estate, LLC	100.00%	100	100	5
6	V	21	Insurance Survey		Grasmere Real Estate, LLC	100.00%	850	850	6
7	V	30	Depreciation		Grasmere Real Estate, LLC	100.00%	358,402	358,402	7
8	V	31	Amortization		Grasmere Real Estate, LLC	100.00%	160,366	160,366	8
9	V	26	Insurance		Grasmere Real Estate, LLC	100.00%	9,398	9,398	9
10	V	32	Interest		Grasmere Real Estate, LLC	100.00%	675,984	675,984	10
11	V	36	MIP Insurance		Grasmere Real Estate, LLC	100.00%	54,950	54,950	11
12	V	33	Real Estate Tax		Grasmere Real Estate, LLC	100.00%	125,660	125,660	12
13	V								13
14	Total			$ 943,613			$ 1,390,109	$ * 446,496	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 64	$ 64	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,948	1,948	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	2,033	2,033	17
18	V	10	Nursing	38	Care Centers, Inc.	100.00%	296	258	18
19	V	11	Activities		Care Centers, Inc.	100.00%	35	35	19
20	V	19	Professional Fees	293,910	Care Centers, Inc.	100.00%	13,022	(280,888)	20
21	V	20	Dues and Subscriptions	19,710	Care Centers, Inc.	100.00%	1,493	(18,217)	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	21,663	21,663	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	937	937	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,611	1,611	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	10,373	10,373	25
26	V	32	Interest		Care Centers, Inc.	100.00%	20,414	20,414	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,894	2,894	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	4,789	4,789	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,266	2,266	29
30	V	25	Bus Reimbursement	4,860	Care Centers, Inc.	100.00%		(4,860)	30
31	V	02	Food	115	Care Centers, Inc.	100.00%		(115)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 318,633			$ 83,838	$ * (234,795)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 20,134	Care Centers, Inc.	100.00%	$ 20,140	$ 6	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	2,580	2,580	16
17	V	10	Nursing Salary		Care Centers, Inc.	100.00%			17
18	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	11	Activity Salary	566	Care Centers, Inc.	100.00%	566		19
20	V	12	Social Service Salary	1,182	Care Centers, Inc.	100.00%	1,182		20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	234	234	21
22	V	17	Administration Salary	104,455	Care Centers, Inc.	100.00%	104,455		22
23	V	21	Office Salary	22,395	Care Centers, Inc.	100.00%	22,395		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	15,537	15,537	24
25	V	22	Employee Benefits	22,310	Care Centers, Inc.	100.00%		(22,310)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 171,042			$ 167,089	$ * (3,953)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 7,884	Care Centers, Inc.	100.00%	$ 4,252	$ (3,632)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%	1,221	1,221	16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	4,470	4,470	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,233	1,233	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	14,115	14,115	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	659	659	20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	196	196	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,822	1,822	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	14,200	14,200	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	140,885	140,885	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	19,162	19,162	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,884			$ 202,215	$ * 194,331	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc. - Health Systems Division	100.00%	$	$	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%			16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%			17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%			18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%			19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%			20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%			21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%			22
23	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%			23
24	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%			24
25	V	39	Ancillary Enteral Supplies		Care Centers, Inc. - Health Systems Division	100.00%			25
26	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%			26
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%			27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 136,043	$ 136,043	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	136,617	CCS EMPLOYEE BENEFIT GROUP	100.00%		(136,617)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 136,617			$ 136,043	$ * (574)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 15,490	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 13,451	$ (2,039)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	35,685	XCEL MEDICAL SUPPLY, LLC	100.00%	30,988	(4,697)	17
18	V	04	LAUNDRY	176	XCEL MEDICAL SUPPLY, LLC	100.00%	153	(23)	18
19	V	06	REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10	NURSING	24,353	XCEL MEDICAL SUPPLY, LLC	100.00%	21,148	(3,206)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE	34	XCEL MEDICAL SUPPLY, LLC	100.00%	30	(4)	22
23	V	21	CLERICAL & GENERAL OFFICE	3,188	XCEL MEDICAL SUPPLY, LLC	100.00%	2,769	(420)	23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 78,927			$ 68,538	$ * (10,389)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Adminstrative		See Attached	1.58	2.87%	Mgmt Fee	$ 180,000	17-3	1
2	Adam Vales	Owner	Clerical	1.85%	See Attached	0.70	1.75%	Alloc Salary	545	22-7	2
3	Mark Steinberg	Relative	Adminstrative		See Attached	2.00	3.96%	Alloc Salary	1,971	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 182,516		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,764,895	42	$ 1,527	$	74,359	$ 64	1
2	05	Utilities	Patient Days	1,764,895	42	46,229		74,359	1,948	2
3	06	Maintenance	Patient Days	1,764,895	42	48,251		74,359	2,033	3
4	10	Nursing	Patient Days	1,764,895	42	7,018		74,359	296	4
5	11	Activities	Patient Days	1,764,895	42	838		74,359	35	5
6	19	Professional Fees	Patient Days	1,764,895	42	309,074		74,359	13,022	6
7	20	Dues and Subscriptions	Patient Days	1,764,895	42	35,428		74,359	1,493	7
8	21	Office & Clerical	Patient Days	1,764,895	42	523,091		74,359	21,663	8
9	24	Travel and Seminar	Patient Days	1,764,895	42	22,233		74,359	937	9
10	26	Insurance	Patient Days	1,764,895	42	38,230		74,359	1,611	10
11	30	Depreciation	Patient Days	1,764,895	42	246,194		74,359	10,373	11
12	32	Interest	Patient Days	1,764,895	42	484,531		74,359	20,414	12
13	33	Real Estate Taxes	Patient Days	1,764,895	42	68,681		74,359	2,894	13
14	34	Rent - Building	Patient Days	1,764,895	42	113,677		74,359	4,789	14
15	35	Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		74,359	2,266	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,998,780	$		$ 83,838	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			213,393	213,393		20,140	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			26,918			2,580	2
3	10	Nursing Salary	Direct Cost			976,718	976,718			3
4	10a	Rehab Salary	Direct Cost			103,898	103,898			4
5	11	Activity Salary	Direct Cost			10,902	10,902		566	5
6	12	Social Service Salary	Direct Cost			306,863	306,863		1,182	6
7	15	Emp. Ben. - Healthcare	Direct Cost			174,348			234	7
8	17	Administration Salary	Direct Cost			1,191,200	1,191,200		104,455	8
9	21	Office Salary	Direct Cost			698,886	698,886		22,395	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			238,998			15,537	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,942,124	$ 3,501,860		$ 167,089	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	74,359	4,252	1
2	03	Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	74,359	1,221	2
3	06	Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	74,359	4,470	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		74,359	1,233	4
5	10	Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	74,359	14,115	5
6	10a	Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	74,359	659	6
7	12	Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	74,359	196	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		74,359	1,822	8
9	17	Administration Salary	Patient Days	1,764,895	42	337,043	337,043	74,359	14,200	9
10	21	Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	74,359	140,885	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		74,359	19,162	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,799,547	$ 4,272,235		$ 202,215	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,073,579		138,556			$	1
2	02	Food	Billable Income	2,073,579		852,614				2
3	06	Maintenance	Billable Income	2,073,579		1,311				3
4	17	Administration	Billable Income	2,073,579		25,000				4
5	19	Professional Fees	Billable Income	2,073,579		8,170				5
6	20	Dues & Subscriptions	Billable Income	2,073,579		2,312				6
7	21	Office & Clerical	Billable Income	2,073,579		53,285				7
8	24	Travel & Seminar	Billable Income	2,073,579		68,680				8
9	32	Interest Expense	Billable Income	2,073,579		571				9
10	35	Rent - Equipment & Auto	Billable Income	2,073,579		13,336				10
11	39	Ancillary Enteral Supplies	Billable Income	2,073,579		114,955				11
12	01	Dietary - Salary	Billable Income	2,073,579		268,554	268,554			12
13	07	Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942				13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,582,287	$ 268,554		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 136,043	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 136,043	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 13,451	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						30,988	3
4	04	LAUNDRY	Direct Allocation						153	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation							5
6	10	NURSING	Direct Allocation						21,148	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation						30	8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation						2,769	9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation							11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 68,538	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Building Partnership		X	Mortgage	$71,078.00	01/26/99	$ 9,518,795	$ 9,500,426			$ 675,984	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Diawa		X								3,482	6
7	Allocate Care Centers		X								20,414	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$71,078.00		$ 9,518,795	$ 9,500,426			$ 699,880	9
	B. Non-Facility Related*											
10												10
11	Interest Income		X								(135,858)	11
12	Interest Income (Bldg Co)		X								(3,089)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (138,947)	14
15	TOTALS (line 9+line14)						$ 9,518,795	$ 9,500,426			$ 560,933	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Grasmere Place **#** 0044271 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	113,791	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	118,227	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,436	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	124,118	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	3,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	132,054	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	106,146	8
	1999	105,434	9
	2000	113,935	10
	2001	116,897	11
	2002	118,227	12

2003 accrual = 2002 tax $118,227 X 1.05 = $124,118

Adjusted beginning accrual by (8,798) to reconcile prior year difference

Care Centers Allocation = $2,894

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044271

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-214-001-0000	Long Term Care Property	$ 114,278.59	$ 114,278.59
2.	14-17-214-002-0000	Long Term Care Property	$ 1,964.43	$ 1,964.43
3.	14-17-214-003-0000	Long Term Care Property	$ 1,984.43	$ 1,984.43
4.	See Attached	Home Office Allocation	$ 68,681.49	$ 2,893.74
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 186,908.94	$ 121,121.19

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grasmere Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044271

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 998,951
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 160,366
4. Dates Incurred: Various

Nature of Costs: Closing Costs, Goodwill
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1999	$ 800,000	1
2	Allocation 2201 Main LLC			21,420	2
3	TOTALS			$ 821,420	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	83,114		20	3,793	3,793	16,169	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		5,949,871	162,499		178,843	16,344	866,701	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		81,022	2,709		2,709		2,883	68
69	Financial Statement Depreciation			20,039			(20,039)		69
70	TOTAL (lines 4 thru 69)		$ 6,114,007	$ 185,247		$ 185,345	$ 98	$ 885,753	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,114,007	$ 185,247		$ 185,345	$ 98	$ 885,753	1
2	Install Tiles	2000	18,700		20	935	935	3,740	2
3	Install Concrete	2000	1,500		20	75	75	300	3
4	Plumbing Renov	2000	4,630		20	232	232	927	4
5	Install Carpeting	2000	588		20	29	29	117	5
6	Install Vct Tile	2000	1,569		20	78	78	313	6
7	Paint	2000	1,046		20	52	52	209	7
8	Electric Renov	2000	10,037		20	502	502	2,008	8
9	Paint	2000			20				9
10	Install Grease Trap	2000	1,142		20	57	57	223	10
11	Paint	2000	1,450		20	73	73	285	11
12	Kitchen Remoldeling	2000	33,147		20	1,657	1,657	6,491	12
13	Bedspreads	2000			20				13
14	Deadlocks	2000	626		20	31	31	120	14
15	Paint	2000	4,866		20	243	243	933	15
16	Refrige Renov	2000	2,200		20	110	110	422	16
17	Steel Doors	2000	3,300		20	165	165	633	17
18	Plaster	2000	15,000		20	750	750	2,813	18
19	Paint	2000	2,611		20	261	261	979	19
20	Radiator Renov	2000	1,616		20	81	81	304	20
21	Plaster/Paint	2000	20,000		20	1,000	1,000	3,667	21
22	Plaster/Paint	2000	2,500		20	125	125	458	22
23	Deposit	2000	17,000		20	850	850	3,117	23
24	Food Processor	2000			20				24
25	Landscaping	2000	2,001		20	100	100	358	25
26	Hot Water Heater Rep	2000	500		20	25	25	90	26
27	Front Door Repair	2000	650		20	33	33	117	27
28	Electric Wiring	2000	21,450		20	1,073	1,073	3,844	28
29	Carpeting Install	2000	11,844		20	592	592	2,121	29
30	Front Door Repair	2000	675		20	34	34	119	30
31	Electrical Wiring	2000	1,923		20	96	96	320	31
32	Plumbing Repair	2000	653		20	33	33	106	32
33	Elevator Repair	2000	4,476		20	224	224	728	33
34	TOTAL (lines 1 thru 33)		$ 6,301,707	$ 185,247		$ 194,861	$ 9,614	$ 921,615	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,301,707	$ 185,247		$ 194,861	$ 9,614	$ 921,615	1
2	Roof Repair	2000	7,220		20	361	361	1,173	2
3	Fire Pump Repair	2000	1,867		20	93	93	319	3
4	Binder Electric	2000	6,332		20	317	317	1,082	4
5	Furniture For Park	2000	12,695		20	635	635	2,170	5
6	Installn Of Bsktbl S	2000	2,304		20	115	115	393	6
7	Nursing Station Cbnt	2000	7,065		20	353	353	1,119	7
8	Cooler Renov	2000	3,052		20	153	153	484	8
9	Fire Alarm	2000	3,169		20	158	158	501	9
10	Plumbing Supplies	2000	980		20	49	49	155	10
11	Alarm Clock	2000			20				11
12	Fire Alarm Repair	2000	2,495		20	125	125	385	12
13	Boiler Repair	2000	2,629		20	131	131	405	13
14	Lavatory Remodeling	2000	603		20	30	30	93	14
15	Replacement Piping	2000	4,996		20	250	250	771	15
16	Installation Of Rdtr	2000	1,507		20	75	75	232	16
17	Radiator Repair	2000	564		20	28	28	86	17
18	Drapes	2000	4,840		20	242	242	746	18
19	Call Station Repair	2000	939		20	47	47	145	19
20	Plumbing Supplies	2000	980		20	49	49	151	20
21	Plumbing	2000	653		20	33	33	163	21
22	Plumbing	2000	1,691		20	85	85	409	22
23	Water Heater Renov	2000	1,603		20	80	80	387	23
24	Toilets	2000	574		20	29	29	134	24
25	Cooler Renov	2000	518		20	26	26	117	25
26	Toilets	2000	653		20	33	33	141	26
27	Toilets	2000	653		20	33	33	141	27
28	Plumbing Repair	2000	1,960		20	98	98	376	28
29	Food Processor	2000	930		20	47	47	171	29
30	Nurse Call Station R	2001	8,231		20	412	412	1,235	30
31	Laundry Room Leak Re	2001	4,748		20	237	237	712	31
32	Piping Repair	2001	532		20	27	27	80	32
33		2001	600		20	30	30	90	33
34	TOTAL (lines 1 thru 33)		$ 6,389,290	$ 185,247		$ 199,242	$ 13,995	$ 936,181	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,389,290	$ 185,247		$ 199,242	$ 13,995	$ 936,181	1
2	New Rods Drapes	2001	765		20	38	38	115	2
3	Heating System Repai	2001	2,283		20	114	114	333	3
4	Water Leak Repair	2001	1,208		20	60	60	176	4
5	Heating System Repai	2001	536		20	27	27	79	5
6	Floor Tiles	2001	2,137		20	107	107	303	6
7	Plumbing Repair In M	2001	2,031		20	102	102	288	7
8	Electrical Supplies	2001	1,574		20	79	79	223	8
9	Bathroom Remodeling	2001	1,000		20	50	50	142	9
10	Bathroom Remodeling	2001	1,200		20	60	60	170	10
11	Paint	2001	1,351		20	68	68	175	11
12	Landscaping	2001	2,115		20	106	106	274	12
13	Plans For Elec.Work	2001	660		20	33	33	85	13
14	Ac Repair	2001	2,065		20	103	103	259	14
15	Ac Repair	2001	510		20	26	26	64	15
16	Boiler Repair	2001	3,279		20	164	164	396	16
17	Plumbing Repair-Kitc	2001	1,886		20	94	94	228	17
18	Boiler Room Repair	2001	2,160		20	108	108	261	18
19	Sliding Gate	2001	1,840		20	92	92	222	19
20	Firebrick Backup Sys	2001	2,297		20	115	115	268	20
21	Tiles	2001	841		20	42	42	98	21
22	Plumbing Repair	2001	1,057		20	53	53	119	22
23	Carpeting	2001	6,145		20	307	307	666	23
24	Tiles	2001	634		20	32	32	68	24
25	Plumbing Repair	2001	4,000		20	200	200	433	25
26	Plumbing Repair	2001	2,052		20	103	103	222	26
27	Sprinkler System Rep	2001	1,750		20	88	88	190	27
28	Freezer Repair	2002	968		20	65	65	97	28
29	Bathroom Remodeling	2002	20,979		20	2,098	2,098	4,196	29
30	Water Leak Repair	2002	767		20	77	77	153	30
31	Control Cabinet For Boiler Room	2002	4,670		20	467	467	934	31
32	Plumbing Supplies	2002	772		20	77	77	154	32
33	Plumbing Supplies	2002	568		20	57	57	114	33
34	TOTAL (lines 1 thru 33)		$ 6,465,390	$ 185,247		$ 204,454	$ 19,207	$ 947,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,465,390	$ 185,247		$ 204,454	$ 19,207	$ 947,686	1
2	Pump Repair	2002	1,832		20	183	183	366	2
3	Pump Repair	2002	670		20	67	67	134	3
4	Boiler Repair	2002	2,159		20	180	180	360	4
5	Drinking Fountain Installation	2002	509		20	51	51	102	5
6	Tub Leak Repair	2002	647		20	65	65	129	6
7	Shower Lever	2002	600		20	40	40	80	7
8	New Drywall In 3 Bathrooms	2002	12,600		20	1,260	1,260	2,415	8
9	Plumbing Repair	2002	877		20	88	88	168	9
10	Plumbing Repair	2002	2,988		20	299	299	573	10
11	Toilet Repair	2002	541		20	36	36	69	11
12	Electric Wiring	2002	768		20	77	77	141	12
13	Plumbing Repair	2002	661		20	66	66	121	13
14	Paint	2002	957		20	96	96	167	14
15	Paint	2002	1,899		20	190	190	317	15
16	Paint	2002	861		20	86	86	144	16
17	Roof Drain Repair	2002	614		20	61	61	102	17
18	Paint	2002	542		20	54	54	86	18
19	Roof Drain Repair	2002	594		20	59	59	94	19
20	Call Lights Replacement	2002	1,197		20	120	120	190	20
21	Plumbing Repair	2002	866		20	87	87	137	21
22	Landscaping	2002	1,956		20	130	130	206	22
23	Tuckpointing	2002	3,000		20	300	300	450	23
24	Key By Code	2002	852		20	85	85	128	24
25	Builders Hardware	2002	535		20	54	54	76	25
26	Tuckpointing	2002	8,475		20	848	848	1,201	26
27	Fire Escape Repair	2002	5,250		20	525	525	744	27
28	Fire Escape Repair	2002	2,500		20	250	250	354	28
29	Tiles	2002	530		20	27	27	38	29
30	Gaskets Installation	2002	1,135		20	114	114	161	30
31	Drywall	2002	550		20	55	55	73	31
32	Electrical Supplies	2002	1,499		20	150	150	200	32
33	Tuckpointing	2002	1,700		20	170	170	227	33
34	TOTAL (lines 1 thru 33)		$ 6,525,754	$ 185,247		$ 210,327	$ 25,080	$ 957,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 6,525,754	$ 185,247		$ 210,327	$ 25,080	$ 957,439	1
2	Quarter Round (455)	2002	699		20	70	70	87	2
3	Vct Tile	2002	2,007		20	201	201	251	3
4	Paint	2002	2,939		20	294	294	367	4
5	Duro-Last Roof	2002	2,900		20	290	290	363	5
6	Window Lintel Replacement	2002	2,500		20	250	250	313	6
7	Boiler Repair	2002	1,455		20	121	121	152	7
8	Thermopak Boiler	2002	1,425		20	119	119	148	8
9	Vct Tile	2002	641		20	64	64	80	9
10	Thermopack Boiler	2002	7,856		20	655	655	764	10
11	Elevator Repair	2002	3,741		20	187	187	218	11
12	Paint	2002	695		20	70	70	81	12
13	Replace Piping	2002	1,325		20	133	133	155	13
14	Replace Piping	2002	802		20	80	80	94	14
15	Lintel Replacement	2002	21,000		20	2,100	2,100	2,450	15
16	Water Leak Repair-Boiler Room	2002	987		20	99	99	197	16
17	Shower Doors	2002	1,095		20	219	219	383	17
18	Ac	2002	603		20	86	86	129	18
19	Ac	2002	2,995		20	428	428	642	19
20	Plumbing Supplies	2002	703		20	141	141	199	20
21	Ac	2002	2,236		20	319	319	453	21
22	Tiles	2002	2,634		20	263	263	285	22
23	Paint	2002	1,832		20	183	183	198	23
24	Stream Lines Leak Repairs	2003	9,731		20	487	487	487	24
25	Pipe Replacement	2003	614		20	31	31	31	25
26	Thermostats Installation	2003	29,291		20	1,465	1,465	1,465	26
27	Doors	2003	11,000		20	550	550	550	27
28	Smoke Detectors Replacement	2003	2,700		20	135	135	135	28
29	Electrical Supplies	2003	620		20	31	31	31	29
30	Plumbing Repair	2003	1,885		20	94	94	94	30
31	Radiators Repairs	2003	1,043		20	52	52	52	31
32	Sidelight Glass	2003	595		20	30	30	30	32
33	Tiles	2003	823		20	41	41	41	33
34	TOTAL (lines 1 thru 33)		$ 6,647,126	$ 185,247		$ 219,615	$ 34,368	$ 968,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,647,126	$ 185,247		$ 219,615	$ 34,368	$ 968,364	1
2	Elevator Repair	2003	1,235		20	57	57	57	2
3	Carpeting	2003	7,651		20	351	351	351	3
4	Elevator Repair	2003	4,297		20	179	179	179	4
5	Installation Of Vent System	2003	15,949		20	665	665	665	5
6	Installation Of Vent System	2003	13,280		20	553	553	553	6
7	New Shower Base	2003	1,203		20	50	50	50	7
8	Tiles	2003	544		20	23	23	23	8
9	5 Doors Install	2003	1,511		20	63	63	63	9
10	Ceiling Tiles	2003	825		20	34	34	34	10
11	Repair Rooms From Water Damage	2003	12,500		20	469	469	469	11
12	Repair Rooms From Water Damage	2003	1,750		20	58	58	58	12
13	Waste Piping Trap	2003	736		20	25	25	25	13
14	Wiring Ac	2003	1,299		20	38	38	38	14
15	Walk-In Freezer Repair	2003	852		20	25	25	25	15
16	Installation Of Vent System	2003	13,067		20	381	381	381	16
17	Installation Of Vent System	2003	12,320		20	359	359	359	17
18	Gas Pipes Repair	2003	659		20	16	16	16	18
19	Gas Pipes Repair	2003	521		20	13	13	13	19
20	Painting Supplies	2003	618		20	13	13	13	20
21	Install Relief Valve	2003	700		20	15	15	15	21
22	Leasehold Improvements	2003	1,375		20	29	29	29	22
23	Leasehold Improvements	2003	1,131		20	19	19	19	23
24	Leasehold Improvements	2003	703		20	12	12	12	24
25	Leasehold Improvements	2003	575		20	10	10	10	25
26	Paint	2003	947		20	12	12	12	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,743,374	$ 185,247		$ 223,084	$ 37,837	$ 971,833	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 6,743,374	$ 185,247		$ 223,084	$ 37,837	$ 971,833	1
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,743,374	$ 185,247		$ 223,084	$ 37,837	$ 971,833	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,743,374	$ 185,247		$ 223,084	$ 37,837	$ 971,833	1
2									2
3									3
4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,743,374	$ 185,247		$ 223,084	$ 37,837	$ 971,833	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 6,743,374	$ 185,247		$ 223,084	$ 37,837	$ 971,833	1
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,743,374	$ 185,247		$ 223,084	$ 37,837	$ 971,833	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 6,743,374	$ 185,247		$ 223,084	$ 37,837	$ 971,833	1
2									2
3									3
4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,743,374	$ 185,247		$ 223,084	$ 37,837	$ 971,833	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	216		1999		$ 5,578,000	$ 143,026		$ 159,371	$ 16,345	$ 783,574	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Grasmere Real Estate LLC			1999	192,580	9,629		9,629		44,935	9
10	Grasmere Real Estate LLC			1999	19,311	966		966	(0)	4,347	10
11	Grasmere Real Estate LLC			1999	1,573	79		79	(0)	349	11
12	Grasmere Real Estate LLC			1999	50,131	2,507		2,507	0	10,864	12
13	Grasmere Real Estate LLC			1999	17,558	1,756		1,756		3,732	13
14	Grasmere Real Estate LLC			1999	90,718	4,536		4,536	(0)	18,900	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,949,871	$ 162,499		$ 178,843	$ 16,345	$ 866,701	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocation - 2201 Main LLC		2002		$ 29,518	$ 738	35	$ 738	$	$ 799	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	27,331	1,367	20	1,367		1,480	9
10	Allocation - 2201 Main LLC			2003	24,173	604	20	604		604	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 81,022	$ 2,709		$ 2,709	$	$ 2,883	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,534,094	$ 199,900	$ 153,721	$ (46,179)	10	$ 736,587	71
72	Current Year Purchases	20,608	352	1,460	1,108	10	1,460	72
73	Fully Depreciated Assets	7,742				10	7,742	73
74								74
75	TOTALS	$ 1,562,444	$ 200,252	$ 155,181	$ (45,071)		$ 745,789	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		ESCORT	2001	$ 8,270	$	$ 827	$ 827	5	$ 1,861	76
77		VOLKSWAGEN NEW BEETLE	2002	11,329		2,889	2,889	5	4,588	77
78		Allocate Care Centers		30,694	3,318	3,318		5	24,153	78
79										79
80	TOTALS			$ 50,293	$ 3,318	$ 7,034	$ 3,716		$ 30,602	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,177,531	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 388,817	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 385,299	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,518)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,748,224	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Care Centers Allocation				4,789			5
6								6
7	TOTAL				$ 4,789 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 10,819 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 29,634	$ 39,506	1
2	Cash-Patient Deposits	26,079	26,079	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	404,786	404,786	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,810	59,726	6
7	Other Prepaid Expenses	22,094	22,094	7
8	Accounts Receivable (owners or related parties)	25,497	25,497	8
9	Other(specify): See Attached Schedule	3,029,282	3,833,286	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,572,182	$ 4,410,974	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		800,000	13
14	Buildings, at Historical Cost		5,578,000	14
15	Leasehold Improvements, at Historical Cost	693,238	1,065,108	15
16	Equipment, at Historical Cost	171,388	1,542,721	16
17	Accumulated Depreciation (book methods)	(98,412)	(1,819,507)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		818,776	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 766,214	$ 7,985,098	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,338,396	$ 12,396,072	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 548,794	$ 548,793	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,181	26,181	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,819	173,819	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,951	5,951	31
32	Accrued Real Estate Taxes(Sch.IX-B)		124,118	32
33	Accrued Interest Payable		44,573	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 754,745	$ 923,435	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,500,426	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,500,426	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 754,745	$ 10,423,861	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,583,651	$ 1,972,211	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,338,396	$ 12,396,072	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,852,830	1
2	Restatements (describe):		2
3	Late Accounting Entries	237,743	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,090,573	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,153,078	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(660,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 493,078	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,583,651	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,382,725	1
2	Discounts and Allowances for all Levels	(594)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,382,131	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	594	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 594	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	135,858	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 135,858	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	22,070	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,070	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,540,653	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,082,320	31
32	Health Care	1,740,799	32
33	General Administration	1,473,599	33
	B. Capital Expense		
34	Ownership	972,597	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	118,260	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,387,575	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,153,078	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,153,078	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,959	2,275	$ 62,916	$ 27.66	1
2	Assistant Director of Nursing	1,902	2,209	55,659	25.20	2
3	Registered Nurses	987	1,033	26,166	25.33	3
4	Licensed Practical Nurses	14,761	16,454	296,753	18.04	4
5	Nurse Aides & Orderlies	53,452	57,842	463,685	8.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,907	2,293	41,424	18.07	9
10	Activity Assistants	7,593	8,351	62,917	7.53	10
11	Social Service Workers	29,035	32,194	481,881	14.97	11
12	Dietician					12
13	Food Service Supervisor	3,598	4,067	47,431	11.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,123	15,231	121,126	7.95	15
16	Dishwashers					16
17	Maintenance Workers	10,442	11,542	116,320	10.08	17
18	Housekeepers	24,564	26,325	196,650	7.47	18
19	Laundry					19
20	Administrator	17	29	1,223	42.17	20
21	Assistant Administrator	241	391	5,420	13.86	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,859	11,314	129,785	11.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,487	1,831	15,787	8.62	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	28,806	29,172	141,232	4.84	33
34	TOTAL (lines 1 - 33)	204,733	222,553	$ 2,266,375 *	$ 10.18	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	361	$ 18,055	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,650	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	736	11-03	44
45	Social Service Consultant	31	1,482	12-03	45
46	Other(specify) Psycho Social	6	300	12-03	46
47	Art Therapist	321	12,858	11-03	47
48	CCI Cost - See Attached		567		48
49	TOTAL (lines 35 - 48)	735	$ 46,976		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	137	5,598	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	137	$ 5,598		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Celeste Jensen	Administrator	0	$ 1,223
Jeremy Boeshes	Admin in Training	0	5,420
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 6,643

B. Administrative - Other

Description	Amount
Eric Rothner - Management Fee	$ 180,000
Nathan Langsner - Management Fee	12,000
CCI Administrative Payroll (adjusted out page 6B)	104,454
TOTAL (agree to Schedule V, line 17, col. 3)	$ 296,454
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consult	$ 6,378
Care Centers, Inc	Ancillary Admin Fees	25,920
Care Centers, Inc	Home Office Expense	181,440
Care Centers, Inc	Bookkeeping	44,064
Care Centers, Inc	Accounting	15,000
FR&R	Accounting	15,888
Michael Best & Friedrich	Legal	9,058
Ira Silverstein	Legal	1,365
Maxxsource	Computer Services	400
HT/Sourcetech	Computer Services	780
Legat Architects	Architects	7,395
See Supplemetal Schedule		42,779
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 350,467

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,873
Unemployment Compensation Insurance	35,211
FICA Taxes	165,925
Employee Health Insurance	99,648
Employee Meals	28,616
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Empl Tax	4,205
Pension Expense	14,011
Misc. Employee Welfare	2,691
Holiday Expense	840
TOTAL (agree to Schedule V, line 22, col.8)	$ 388,020

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,741
Health Care Worker Background Check	1,970
(Indicate # of checks performed 164)	
Licenses and Fees	4,786
Dues and Subscriptions	8,467
Allocate Care Centers	1,493
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,457

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,408
Allocate Care Center	937
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,345

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC - $10,342

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ None Line N/A

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 118,260
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 28,616 Has any meal income been offset against related costs? No Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.